		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0015651

Facility Name: Bethany Terrace Ret & N H

Address: 8425 North Waukegan (Number) Morton Grove (City) 60053 (Zip Code)

County: Cook

Telephone Number: (847) 965-8100 **Fax #** ( )

IDPA ID Number: 36-2012788

Date of Initial License for Current Owners: 02/13/69

Type of Ownership:

[X]	VOLUNTARY,NON-PROFIT	[ ]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[ ]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

IRS Exemption Code

In the event there are further questions about this report, please contact:
Name: Harold Reisler **Telephone Number:** (773) 989-1465

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/99 to 9/30/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Wolfgang Mayer

(Title) Vice President

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) David T. Brown, Senior Associate

(Firm Name & Address) PricewaterhouseCoopers
203 North LaSalle Street, Chicago, IL 60601

(Telephone) (312) 701-5723 Fax # (312) 701-2079

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 Report Period Beginning: 10/01/99 Ending: 9/30/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 4/13/92

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	103	Skilled (SNF)	103	37,698	1
2		Skilled Pediatric (SNF/PED)			2
3	160	Intermediate (ICF)	160	58,560	3
4		Intermediate/DD			4
5	2	Sheltered Care (SC)	2	732	5
6		ICF/DD 16 or Less			6
7	265	TOTALS	265	96,990	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	3,963	7,079	4,093	15,135	8
9	SNF/PED					9
10	ICF	18,072	56,220		74,292	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	22,035	63,299	4,093	89,427	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 92.20%

D. How many bed-hold days during this year were paid by Public Aid? 354 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
Meals on Wheels

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 2/13/65

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 29 and days of care provided 4,093

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 9/30/00 Fiscal Year: 9/30/00

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 Report Period Beginning: 10/01/99 Ending: 9/30/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	528,500	50,759	(79,973)	499,286		499,286	(48,969)	450,317			1
2	Food Purchase		642,336		642,336		642,336		642,336			2
3	Housekeeping	264,756	35,158	92,396	392,310		392,310		392,310			3
4	Laundry	45,624	3,383	216,630	265,637		265,637		265,637			4
5	Heat and Other Utilities			172,819	172,819		172,819		172,819			5
6	Maintenance	144,904	43,816	150,002	338,722		338,722		338,722			6
7	Other (specify):* Security		766		766		766		766			7
8	**TOTAL General Services**	983,784	776,218	551,874	2,311,876		2,311,876	(48,969)	2,262,907			8
	B. Health Care and Programs											
9	Medical Director											9
10	Nursing and Medical Records	4,368,226	490,688	96,866	4,955,780		4,955,780		4,955,780			10
10a	Therapy	290,172	30,386	318,148	638,706		638,706		638,706			10a
11	Activities	99,755	4,314	24,816	128,885		128,885		128,885			11
12	Social Services	106,654	136	11,360	118,150		118,150		118,150			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):* Pastoral Care	52,473	723	4,486	57,682		57,682		57,682			15
16	**TOTAL Health Care and Programs**	4,917,280	526,247	455,676	5,899,203		5,899,203		5,899,203			16
	C. General Administration											
17	Administrative	132,790		372,968	505,758		505,758	(190,537)	315,221			17
18	Directors Fees											18
19	Professional Services			68,367	68,367		68,367	(37,151)	31,216			19
20	Dues, Fees, Subscriptions & Promotions			63,971	63,971		63,971	(30,795)	33,176			20
21	Clerical & General Office Expenses	199,505	21,451	359,421	580,377		580,377	(10,122)	570,255			21
22	Employee Benefits & Payroll Taxes			742,139	742,139		742,139		742,139			22
23	Inservice Training & Education											23
24	Travel and Seminar			14,663	14,663		14,663		14,663			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			88,441	88,441		88,441		88,441			26
27	Other (specify):* Volunteers	35,721	1,470	1,433	38,624		38,624		38,624			27
28	**TOTAL General Administration**	368,016	22,921	1,711,403	2,102,340		2,102,340	(268,605)	1,833,735			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,269,080	1,325,386	2,718,953	10,313,419		10,313,419	(317,574)	9,995,845			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Bethany Terrace Ret & N H #0015651 Report Period Beginning: 10/01/99 Ending: 9/30/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			568,127	568,127		568,127		568,127			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			69,386	69,386		69,386		69,386			35
36	Other (specify):*											36
37	**TOTAL Ownership**			637,513	637,513		637,513		637,513			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			2,278	2,278	(2,278)						41
42	Provider Participation Fee											42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			2,278	2,278	(2,278)						44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	6,269,080	1,325,386	3,358,744	10,953,210	(2,278)	10,950,932	(317,574)	10,633,358			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 Report Period Beginning: 10/01/99 Ending: 9/30/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(48,969)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(6,831)	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(71,237)	Var		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (127,037)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(190,537)	17	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (190,537)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (317,574)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39						39
40	Gift and Coffee Shops	X		(2,278)	41	40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	**TOTAL (C): (sum of lines 38-46)**			$ (2,278)		47

STATE OF ILLINOIS

Bethany Terrace Ret & N H

ID# 0015651

Report Period Beginning: 10/01/99

Ending: 9/30/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Special Revenue	$ (3,057)	21	1
2	Health Information Management Misc. Income	(234)	21	2
3	Public Relations	(30,795)	20	3
4	Non Allowable Consulting	(16,991)	19	4
5	Non Allowable Marketing	(20,160)	19	5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
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36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49				49
50				50
51				51
52				52
53				53
54				54
55				55
56				56
57				57
58				58
59				59
60				60
61				61
62				62
63				63
64				64
65				65
66				66
67				67
68				68
69				69
70				70
71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	(71,237)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 **Report Period Beginning:** 10/01/99 **Ending:** 9/30/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(48,969)	0	0	0	0	0	0	0	0	0	0	(48,969)	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(48,969)	0	0	0	0	0	0	0	0	0	0	(48,969)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	(190,537)	0	0	0	0	0	0	0	0	0	0	(190,537)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(37,151)	0	0	0	0	0	0	0	0	0	0	(37,151)	19
20	Fees, Subscriptions & Promotions	(30,795)	0	0	0	0	0	0	0	0	0	0	(30,795)	20
21	Clerical & General Office Expenses	(10,122)	0	0	0	0	0	0	0	0	0	0	(10,122)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(268,605)	0	0	0	0	0	0	0	0	0	0	(268,605)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(317,574)	0	0	0	0	0	0	0	0	0	0	(317,574)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Bethany Terrace Ret & N H** **#** **0015651** **Report Period Beginning:** **10/01/99** **Ending:** **9/30/00**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	0	0	0	0	0	0	0	0	0	0	0	0	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(317,574)	0	0	0	0	0	0	0	0	0	0	(317,574)	45

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 Report Period Beginning: 10/01/99 Ending: 9/30/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		Hospital Admin	$ 54,380	Methodist Hospital of Chicago	100.00%	$	$ (54,380)	1
2	V		Hospital Accounting	76,472	Methodist Hospital of Chicago	100.00%	76,472		2
3	V		Hospital EDP	35,681	Methodist Hospital of Chicago	100.00%	35,681		3
4	V		Corporate Other	84,811	Methodist Hospital of Chicago	100.00%	46,646	(38,165)	4
5	V		Hospital Pastoral Care		Methodist Hospital of Chicago	100.00%			5
6	V		Corporate Prof Fees	34,221	Methodist Hospital of Chicago	100.00%	18,822	(15,399)	6
7	V		Corporate Salary	70,885	Methodist Hospital of Chicago	100.00%	38,986	(31,899)	7
8	V		Corporate Benefits	87,404	Methodist Hospital of Chicago	100.00%	36,710	(50,694)	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 443,854			$ 253,317	$ * (190,537)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 Report Period Beginning: 10/01/99 Ending: 9/30/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 Report Period Beginning: 10/01/99 Ending: 9/30/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Methodist Hospital of Chicago
Street Address: 5025 North Paulina
City / State / Zip Code: Chicago, IL
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		Corporate Salary	% to Total Cost	100	Various	$ 283,538	$	25	$ 70,885	1
2										2
3		Corporate Benefits	% to Total Cost	100	Various	349,616		25	87,404	3
4										4
5		Corporate Professional Fees	% to Total Cost	100	Various	136,885		25	34,221	5
6										6
7		Hospital Administration	% to Total Cost	100	Various	217,520		25	54,380	7
8										8
9		Hospital Pastoral Care	% to Total Cost	100	Various	0		50	0	9
10										10
11		Hospital Accounting	% to Total Cost	100	Various	305,886		25	76,472	11
12										12
13		Hospital Data Processing	% to Total Cost	100	Various	396,452		9	35,681	13
14										14
15		Hospital Other	% to Total Cost	100	Various	339,243		25	84,811	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,029,140	$		$ 443,854	25

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 Report Period Beginning: 10/01/99 Ending: 9/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Not Applicable						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Bethany Terrace Ret & N H **#** 0015651 **Report Period Beginning:** 10/01/99 **Ending:** 9/30/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1995	8
	1996	9
	1997	10
	1998	11
	1999	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 Report Period Beginning: 10/01/99 Ending: 9/30/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,175 B. General Construction Type: Exterior _____ Frame _____ Number of Stories _____

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Not Applicable

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	183,600	1965	$ 189,809	1
2	Terrace Land Triangle		1996	92,064	2
3	TOTALS	183,600		$ 281,873	3

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 Report Period Beginning: 10/01/99 Ending: 9/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	265		1965	1965	$ 1,332,134	$ 9,045	40	$ 9,045	$	$ 1,310,694	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Electrical			1997	1,671	83	20	83		293	10
11	Refrigeration			1997	689	69	10	69		241	11
12	Refrigeration Unit Deep Freezer			1997	2,720	272	10	272		952	12
13	Wall Hanging			1997	700	140	5	140		490	13
14	Wall Hanging			1997	700	140	5	140		490	14
15	Wall HangingVideo Maste Security			1997	11,179	2,236	5	2,236		7,826	15
16	Exit Door System Security Monitor			1997	4,600	460	10	460		1,610	16
17	Security Monitor			1997	1,572	314	5	314		1,100	17
18	Window Coverings			1997	1,993	398	5	398		1,395	18
19	Mechanical Insulation			1999	22,595	1,130	20	1,130		1,695	19
20	New Doors			1999	9,679	645	15	645		968	20
21	Door Replacement/Carpentry			1999	16,901	845	20	845		1,268	21
22	New Piping			1999	2,400	120	20	120		180	22
23	Carpentry			1999	5,041	252	20	252		378	23
24	Chapel Renovation			1999	98,934	4,947	20	4,947		7,420	24
25	Landscaping			1999	10,191	510	20	510		765	25
26	Upper Parking Lot Paving			1999	13,450	897	15	897		1,345	26
27	Chapel Dining Hall Sound System			1999	8,550	855	10	855		1,283	27
28	D 336 Motor			1999	1,979	198	10	198		297	28
29	Emergency Generator			1999	184,029	9,201	20	9,201		13,802	29
30	Vinyl Flooring			1999	819	82	10	82		123	30
31	Fuel Storage Tank Upgrade			1999	9,360	1,170	8	1,170		1,755	31
32	Bi-Fuel Conversion System			1999	12,400	620	20	620		930	32
33	Gasoline for Bi-Fuel Conversion			1999	6,500	325	20	325		488	33
34	Garbage Disposal			1999	1,731	346	5	346		519	34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,762,517	$ 35,300		$ 35,300	$	$ 1,358,307	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 Report Period Beginning: 10/01/99 Ending: 9/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvements and Fixed Equipment										9
10											10
11	Soil Pipe			1998	2,540	169	15	169		423	11
12	Acoustical Ceiling			1998	1,488	99	15	99		248	12
13	Plate Glass Replacement			1998	2,825	282	10	282		706	13
14	Terrace Remolding			1998	178,041	8,902	20	8,902		22,255	14
15	Generator			1998	695	139	5	139		348	15
16	Electrical			1998	530	26	20	26		66	16
17	Booster Heater			1998	2,417	483	5	483		1,208	17
18	Carpeting			1998	4,766	953	5	953		2,383	18
19	Locknetics Delayed Egress System			1998	2,957	591	5	591		1,478	19
20	MBS Delayed Egress System			1998	1,643	109	15	109		274	20
21	Water Cooler			1998	1,395	93	15	93		232	21
22	Carpeting			1998	1,831	366	5	366		915	22
23	Generator			1998	1,286	257	5	257		643	23
24	Window AC			1998	1,713	343	5	343		857	24
25	Ballast Lamp			1998	2,885	577	5	577		1,443	25
26	Convector Motor			1998	886	89	10	89		222	26
27	Cabinets (Wall)			1998	2,274	152	15	152		380	27
28	300 Series Tellabs Modem			1998	1,211	242	5	242		605	28
29	PT Day Care Parking			1997	1,372,256	34,306	40	34,306		120,071	29
30	Architectural Building			1997	2,608	261	10	261		913	30
31	Roofing			1997	777	39	20	39		136	31
32	Renovation			1997	376	25	15	25		88	32
33	Electrical Lighting			1997	768	38	20	38		133	33
34	Painting			1997	1,346	269	5	269		942	34
35	Building Renovations			1997	605	40	15	40		140	35
36	TOTAL (lines 4 thru 35)				$ 1,590,119	$ 48,850		$ 48,850	$	$ 157,109	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 Report Period Beginning: 10/01/99 Ending: 9/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Building Renovation			1997	820	55	15	55		192	10
11	Lighting			1997	435	29	15	29		101	11
12	Painting			1997	2,813	562	5	562		1,969	12
13	Painting			1997	435	87	5	87		305	13
14	Receiving Door			1996	1,327	133	10	133		199	14
15	AMHU Outpatient Clinic			1996	5,387	359	15	359		1,616	15
16	Roofing Repairs			1996	5,300	530	10	530		2,385	16
17	Bethany Terrace Roof			1996	4,950	495	10	495		2,228	17
18	Hallway Doors			1996	1,585	75	10	75		338	18
19	Terrace Remodel			1996	1,353,487	90,233	15	90,233		406,046	19
20	Hallway Doors			1996	835	84	15	84		376	20
21	PT Addition - Windows, Walls, Floors			1996							21
22	PT Addition - HVAC			1996							22
23	PT Addition - Plumbing and Electric			1996							23
24	PT Addition - Fire Protection			1996							24
25	PT Addition - Other Hardware and Materials			1996							25
26	Communication System			1996	6,993	699	10	699		3,146	26
27	Personal Protection Station			1996	1,029	103	10	103		463	27
28	Ceiling Fans			1996	528	43	12	43		199	28
29	Electronic Ballast Reflectors			1996	1,017	102	10	102		459	29
30	Whirlpool & Lift Bath Trolley			1996	14,287	953	15	953		4,286	30
31	Cable Communications Lines			1996	10,940	1,368	8	1,368		6,154	31
32	Building Improvement			1995	2,067	206	various	206		1,138	32
33	Building Improvement			1994	153,823	15,384	various	15,384		99,991	33
34	Building Improvement			1993	312,496	31,827	various	31,827		238,698	34
35	Building Improvement			1992	1,292,987	99,825	various	99,825		848,525	35
36	TOTAL (lines 4 thru 35)				$ 3,173,541	$ 243,152		$ 243,152	$	$ 1,618,814	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 Report Period Beginning: 10/01/99 Ending: 9/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10	Building Improvement			1990	2,272	151	various	151		1,590	10
11	Building Improvement			1989	310,817	19,472	various	19,472		187,519	11
12	Building Improvement			1988	201,082	11,700	various	11,700		148,434	12
13	Building Improvement			1987	56,094	3,118	various	3,118		42,070	13
14	Building Improvement			1986	567,475	27,746	various	27,746		443,082	14
15	Building Improvement			1985	590,655	22,108	various	22,108		491,169	15
16	Building Improvement			1984	103,384	4,093	various	4,093		89,057	16
17	Building Improvement			1983	258,058	3,333	various	3,333		249,727	17
18	Building Improvement			1982	73,203	3,660	various	3,660		67,713	18
19	Building Improvement			1977	99,673		various			99,673	19
20	Building Improvement			1976	116,001		various			116,001	20
21	Building Improvement			1975	60,024	2,001	various	2,001		51,021	21
22	Building Improvement			1973	68,384	2,136	various	2,136		58,767	22
23	Building Improvement			1969	1,009		various			1,009	23
24	Land Improvement			1995	9,325	933	various	933		5,129	24
25	Land Improvement			1994	1,460	122	various	122		792	25
26	Land Improvement			1992	3,175	318	various	318		2,699	26
27	Land Improvement			1991	32,880	3,184	various	3,184		31,288	27
28	Land Improvement			1988	98,170	3,935	various	3,935		51,676	28
29	Land Improvement			1987	25,697		various			25,697	29
30	Land Improvement			1981	14,029		various			14,029	30
31	Land Improvement			1976	23,016		various			23,016	31
32	Land Improvement			1973	31,119		various			31,119	32
33	Land Improvement			1969	16,930		various			16,930	33
34	Land Improvement			1968	3,770		various			3,770	34
35	Land Improvement			1966	10,662		various			10,662	35
36	TOTAL (lines 4 thru 35)				$ 2,778,364	$ 108,010		$ 108,010	$	$ 2,263,639	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 Report Period Beginning: 10/01/99 Ending: 9/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvement			1965	10,416		various			10,416	9
10	Fixed Equipment			1995	82,231	6,037	various	6,037		35,386	10
11	Fixed Equipment			1994	156,214	10,812	various	10,812		108,386	11
12	Fixed Equipment			1993	50,962	1,251	various	1,251		46,499	12
13	Fixed Equipment			1992	59,368	814	various	814		58,002	13
14	Fixed Equipment			1991	14,721	74	various	74		14,312	14
15	Fixed Equipment			1990	13,740	628	various	628		13,740	15
16	Fixed Equipment			1989	23,215		various			23,215	16
17	Fixed Equipment			1988	21,978		various			21,978	17
18	Fixed Equipment			1987	100,453		various			100,453	18
19	Fixed Equipment			1986	89,860	4,714	various	4,714		82,843	19
20	Fixed Equipment			1985	20,277	567	various	567		18,380	20
21	Fixed Equipment			1984	20,155		various			20,155	21
22	Fixed Equipment			1982	1,830		various			1,830	22
23	Fixed Equipment			1981	1,645		various			1,645	23
24	Fixed Equipment			1980	20,928	478	various	478		20,928	24
25	Fixed Equipment			1979	24,316		various			24,316	25
26	Fixed Equipment			1978	3,156		various			3,156	26
27	Fixed Equipment			1977	3,630		various			3,630	27
28	Fixed Equipment			1975	416		various			416	28
29	Fixed Equipment			1974	3,854		various			3,854	29
30	Fixed Equipment			1973	1,960		various			1,960	30
31	Fixed Equipment			1972	410		various			410	31
32	Fixed Equipment			1971	3,018		various			3,018	32
33	Fixed Equipment			1970	9,003		various			9,003	33
34	Fixed Equipment			1968	5,438		various			5,438	34
35	Fixed Equipment			1967	145,657		various			145,657	35
36	TOTAL (lines 4 thru 35)				$ 888,851	$ 25,375		$ 25,375	$	$ 779,026	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 Report Period Beginning: 10/01/99 Ending: 9/30/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Fixed Equipment			1966	62,218		various			62,218	9
10	Fixed Equipment			1965	699,657		various			699,657	10
11											11
12	Paving Stones & Interlocking Paving			2000	5,300	265	10	265		265	12
13	Stoning Grading/Main St.			2000	14,029	701	10	701		701	13
14	Stairs & Concrete Walk Main St. Entrance			2000	4,475	56	40	56		56	14
15	Sealcoat Asbury Parking Lot			2000	2,271	142	8	142		142	15
16	Paving for Bus and Van			2000	3,390	212	8	212		212	16
17	Fence Around Generator			2000	2,491	83	15	83		83	17
18	Terrace Remolding			2000	284,128	3,552	40	3,552		3,552	18
19	Aluminum Floor In Walk In Coolers			2000	4,165	208	10	208		208	19
20	Convention Oven			2000	4,792	240	10	240		240	20
21	Garbage Disposal			2000	2,348	235	5	235		235	21
22	Electro Magnetic Locking Devices			2000	10,658	533	10	533		533	22
23	Boiler Upgrade For Duel Fuel Source			2000	5,217	130	20	130		130	23
24	Software For Call Acct. System			2000	3,214	321	5	321		321	24
25	ID Card Reading System			2000	5,831	292	10	292		292	25
26											26
27											27
28	Subtotal from page 12				1,762,517	35,300		35,300		1,358,307	28
29	Subtotal from page 12A				1,590,119	48,850		48,850		157,109	29
30	Subtotal from page 12B				3,173,541	243,152		243,152		1,618,814	30
31	Subtotal from page 12C				2,778,364	108,010		108,010		2,263,639	31
32	Subtotal from page 12D				888,851	25,375		25,375		779,026	32
33											33
34	Reconciliation Adjustment				29,165					44,063	34
35											35
36	TOTAL (lines 4 thru 35)				$ 11,336,741	$ 467,657		$ 467,657	$ 0	$ 6,989,803	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 Report Period Beginning: 10/01/99 Ending: 9/30/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 1,419,895	$ 90,013	$ 90,013	$	Various	$ 902,887	37
38	Current Year Purchases	136,820	10,457	10,457		Various	10,457	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 1,556,715	$ 100,470	$ 100,470	$		$ 913,344	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Resident Activities	1988 Ford Van	1988	$ 35,783	$	$	$		$ 35,783	42
43	Facility Maintenance	1988 Ford Wagon	1998	16,826					16,826	43
44	Yard Maintenance	International Tractor	1970	3,000					3,000	44
45										45
46	TOTALS			$ 55,609	$	$	$		$ 55,609	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 13,230,938	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 568,127	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 568,127	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 7,958,756	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52		$	$	$	52
53					53
54					54
55					55
56					56
57	TOTALS	$	$	$	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 69,386 Description:
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 Report Period Beginning: 10/01/99 Ending: 9/30/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$	205	$ 9,049	$	205	$ 9,049	1
2	Licensed Speech and Language Development Therapist		hrs		330	13,860		330	13,860	2
3	Licensed Recreational Therapist		hrs		139	5,729		139	5,729	3
4	Licensed Physical Therapist	10A, Col. 1	7911 hrs	178,237	162	7,285		8,073	185,522	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Respiratory Therapy	10A, Col. 1	6382	111,935				6,382	111,935	13
14	TOTAL			$ 290,172	836	$ 35,923	$	15,129	$ 326,095	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Bethany Terrace Ret & N H **#** 0015651 **Report Period Beginning:** 10/01/99 **Ending:** 9/30/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 9/30/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$	$ 2,126,487	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance 2,431,373)		10,267,548	3
4	Supply Inventory (priced at)		465,709	4
5	Short-Term Investments		8,028,719	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses		929,301	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Assets Limited in Use		62,500	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$	$ 21,880,264	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable		792,600	11
12	Long-Term Investments		8,368,813	12
13	Land		33,684	13
14	Buildings, at Historical Cost		20,248,009	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (spe Intangible Assets		1,522,500	22
23	Other(specify):		200,000	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$ 31,165,606	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$	$ 53,045,870	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$	$ 2,627,843	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable		550,000	29
30	Accrued Salaries Payable		2,529,375	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Estimated Third-Party Settlements		1,075,086	36
37	Other		442,684	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$	$ 7,224,988	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable		550,000	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	Estimated Future Service Obligation		117,459	43
44	Other		1,085,766	44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$ 1,753,225	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$	$ 8,978,213	46
47	**TOTAL EQUITY(page 18, line 24)**	$	$ 44,067,657	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$	$ 53,045,870	48

***(See instructions.)**

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 Report Period Beginning: 10/01/99 Ending: 9/30/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 41,010,177	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 41,010,177	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,173,734	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Corporate Income	1,883,746	15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 3,057,480	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 44,067,657	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 Report Period Beginning: 10/01/99 Ending: 9/30/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 16,609,100	1
2	Discounts and Allowances for all Levels	(4,477,238)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 12,131,862	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	4,188	12
13	Barber and Beauty Care		13
14	Non-Patient Meals	48,969	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	3,291	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 56,448	23
	D. Non-Operating Revenue		
24	Contributions	6,831	24
25	Interest and Other Investment Income***	24,000	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 30,831	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 12,219,141	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,032,984	31
32	Health Care	7,035,496	32
33	General Administration	2,258,923	33
	B. Capital Expense		
34	Ownership		34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	149,877	36
	D. Other Expenses (specify):		
37	Depreciation Expense	568,127	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 11,045,407	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,173,734	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,173,734	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 Report Period Beginning: 10/01/99 Ending: 9/30/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	46,445	46,445	964,009	20.76	3
4	Licensed Practical Nurses	29,256	29,256	469,694	16.05	4
5	Nurse Aides & Orderlies	225,030	225,030	2,210,407	9.82	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	19,059	19,059	406,243	21.32	7
8	Rehab/Therapy Aides	1,993	1,993	35,331	17.73	8
9	Activity Director	7,019	7,019	60,580	8.63	9
10	Activity Assistants	6,990	6,990	98,254	14.06	10
11	Social Service Workers					11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	55,189	55,189	504,399	9.14	14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers	8,108	8,108	138,046	17.03	17
18	Housekeepers	32,132	32,132	248,359	7.73	18
19	Laundry	4,248	4,248	41,317	9.73	19
20	Administrator					20
21	Assistant Administrator					21
22	Other Administrative	48,397	48,397	677,592	14.00	22
23	Office Manager					23
24	Clerical					24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	483,866	483,866	$ 5,854,231 *	$ 12.10	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$		35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant				45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 Report Period Beginning: 10/01/99 Ending: 9/30/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kenneth Kolich	Administrator	0	$ 89,396
Arlene Wadja	Asst. Administrator	0	43,394
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 132,790

B. Administrative - Other

Description	Amount
Corporate Allocation	$ 372,968
TOTAL (agree to Schedule V, line 17, col. 3)	$ 372,968
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Gardner, Carton & Douglas	Legal Fees	$ 739
Frost Ruttenberg & Rothblatt	Legal Fees	600
Diane Cernivio & Associates	Legal Fees	9,246
Cassiday, Shade & Gloor	Legal Fees	21,124
Schwad Rehab Hospital & Care	Consulting Fees	2,475
Rush Alzheimer's Disease Ctr	Consulting Fees	3,340
Deloitte & Touche LLP	Consulting Fees	7,000
Milliman & Robertson	Consulting Fees	2,233
Falk Associates	Consulting Fees	20,160
Various	Various	1,450
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 68,367

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 68,937
Unemployment Compensation Insurance	5,443
FICA Taxes	451,877
Employee Health Insurance	184,655
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Lfie Insurance	10,506
Union Benefits	17,027
Tuition Reimbursement	655
Other	3,039
TOTAL (agree to Schedule V, line 22, col.8)	$ 742,139

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	18,608
Health Care Worker Background Check	
(Indicate # of checks performed)	
Marketing	30,795
Dues and Subscriptions	13,623
Publishing	576
Other	369
Less: Public Relations Expense	(30,795)
Non-allowable advertising	(0)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 33,176

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,012
Other	1,349
Seminar Expense	9,302
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 14,663

**See instructions.

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 Report Period Beginning: 10/01/99 Ending: 9/30/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Bethany Terrace Ret & N H # 0015651 **Report Period Beginning:** 10/01/99 **Ending:** 9/30/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **LIPR Serives Network $ 3,613.98**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10 Years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **80,455** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **149,877**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **17,385**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation. N/A
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **0**
d. Have vehicle usage logs been maintained? **None**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **PricewaterhouseCoopers** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **Yes** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.